Terms of Agreement

Acknowledgement of Discount Fees

The client acknowledges that these fees are discounted and not usual and customary fees of Dorn Chiropractic, LLC. As such, the client understands that these fees will only be offered for as long as the client is directly paying Dorn Chiropractic for the services and no third party is being billed by DFC. If the client wishes to submit receipts directly to an insurance carrier, said receipts will reflect cash fees only.

Visits Covered by Insurance

A portion of the care provided under this agreement may be covered by the client's health insurance. The client understands that payments paid are applied to any deductible, copays and/or included care not covered by insurance. The client further understands that if their health insurance benefits should change, that DC reserves the right to change this plan.

Additional Visits Provided During Plan

Additional visits may be purchased at our "pay per visit" cash fees.

Not Covered Under Program

This arrangement does not include biofeedback, massage services, nutritional products, or after hours care.

Termination of Care

The Client can terminate care at any time. With Option 3, the account will be prorated based on the monthly fee. Any overpayment will be refunded within ten business days of canceling care.

Changes in Status

The client is responsible to notify DC within 72 hours if personal circumstances change due to an injury incurred due to either work or automobile accident.

Program Extension Due to Temporary Disruption in Care

In the event the client assigns health insurance benefits to DC, or insurance benefits become available because of a workers compensation or personal injury claim, or for any other reason; the client understands that DC will suspend this agreement while treating the client for any accident related injuries. Care provided during said extension will be at DC's usual and customary fees. DC will resume treatment under this plan once the client has recovered from said injury and has been released from treatment.

Automatic Renewal

Recurring payments will continue indefinitely or until the client terminates the care plan.

This Plan IS NOT Insurance

This agreement does not constitute insurance and as such DC makes no promises to treat new conditions under this agreement.

No Guarantee of Results

The client recognizes that this agreement is not a guarantee of clinical results, and that it deals solely with financial and time obligations. There is no guarantee that any illness, injury or disease can be prevented or cured by participation in this program. Any balance due for services are due regardless of results.

Complete Agreement

This agreement is non-transferable and constitutes the complete agreement between the client and Dorn Chiropractic. No other chiropractic facilities are covered by this agreement. This agreement may be modified by Dorn Chiropractic with 30 days of written notice.

AGREEMENT

I, _____, have read and accept the terms of this agreement.

- Start Date: _____ End Date: _____ □ On-going

Client/Guarantor's Signature: _____ Date Signed: _____

Print Name: _____ Witness Signature: _____

AUTO-DEBIT PAYMENT AUTHORIZATION

Credit Card Type: _____ Name on Card: _____ Bank Name: _____

Credit Card Number: _____ Expiration Date: _____ Security Code: _____

OR

Bank Routing Number: _____ Bank Account Number: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Card Holder's Signature: _____ Date Signed: _____ Email Address: _____

All paper documentation will be appropriately destroyed once the information has been securely stored. You may use a credit card, debit card or a checking account. A checking account is preferred because there is no expiration date

ADDITIONAL VISIT PAYMENT AUTHORIZATION

If the client utilizes more than the total services, a charge based on the PAY-PER-VISIT FEE will be calculated. I hereby authorize Dorn Chiropractic to add this balance to my monthly payment to be drawn on my account listed hereon and agree to perform the obligations set forth by the issuer (initial) _____.

EXTRA SERVICES/SUPPLIES AUTHORIZATION

If the client requires additional care or supplies deemed necessary by Dr. Dorn during the office visit, I hereby authorize Dorn Chiropractic to add any additional charges to my monthly payment to be drawn on my account listed hereon and agree to perform the obligations set forth by the issuer (initial) _____.

ADDITIONAL INFORMATION

Dorn Chiropractic requires that all co-pays and office visit payments are due at the time of service. Our office will not mail out unpaid bills and if there is an outstanding balance, the balance will be charged to the payment information on file at the end of the month. Please discuss any questions you may have with Ann or call her at (262) 560-9600.